Overview of GPRA and CRS 2006

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CRS
(Clinical Reporting System)

- RPMS software application for tracking clinical quality measures, as well as GPRA (Government Performance and Results Act) clinical performance data
  - IHS direct sites are required to use for reporting
- Can be used locally for specific public health performance initiatives

RPMS = Really Powerful at Measuring Stuff

Today's Agenda

- Clinical Performance Overview: Why Use CRS?
  - Overview of GPRA, GPRA 2006 Measures
  - Relationship Between GPRA and CRS
  - GPRA FY05 Results
- CRS 2006
  - Background Information
  - Performance Measures 101
  - Status of Versions 6.0 & 6.1
  - Standard Codes, Taxonomies, Reports & Patient Lists
- Demo of CRS Version 6.0 & GUI
- Common Reasons for Low Rates
- Tips for Improvement
- Improving GPRA Performance Requires a Team Effort!

Clinical Performance Overview – Why Use CRS?

Measuring Quality of Health Care for AI/AN

External Reporting: GPRA

- The Government Performance and Results Act (GPRA)
  - Is a Federal law requiring a data-supported audit trail from appropriated dollars to activities and ultimately to customer benefits or outcomes consistent with an agency's mission
  - Requires an annual performance plan, as well as an annual report

Annual Performance Plan

Must include:

- Performance goals or measures for the fiscal year
- Description of resources needed to meet the goals
- Projected fiscal cost of reaching performance measure goal as total % of budget
- How data to be reported is verified and validated (subject to audit by OMB)
  - Use CRS for reporting of clinical measures
  - Benchmark measures to industry standards (HEDIS, Healthy People 2010, etc.)

Annual Performance Report

Must include:

- What was actually accomplished in comparison to goals in Plan
- If goals were not met, why not
- Plan for achieving unmet goals or reasons why goal is impractical or infeasible

The Role of GPRA Today

- The GPRA Annual Performance Report remains the most important set of annual measures
- The Director's performance contract with the Secretary is largely based on GPRA annual measures
- Area Directors' performance contracts with the IHS Director are largely based on GPRA annual measures
  - Service Unit Director/ CEOs performance assessment are increasingly based on GPRA annual measures

Impact of GPRA Measures

- IHS Budget
  - Goal is to meet 80% of the measures
  - Agency performance on GPRA is intimately tied to the budget submissions
  - If GPRA performance is low, potential for less money = negative impact on our patients

Impact of GPRA Measures

- Area Directors
  - Goal is to meet 80% of the measures
  - SES bonuses tied to AD performance contract (that includes GPRA annual measures)
- Providers
  - GPRA measures should be included in PAS measurements
  - PAS requires that they meet some % of the measures

GPRA Measure Categories

- Treatment: FY06 21 measures
  - e.g., Diabetes, cancer screening, oral health
- Prevention: FY06 12 measures
  - e.g., immunizations, tobacco cessation intervention, childhood weight control, etc.
- Capital Programming/Infrastructure: FY06 3 measures

The Clinical Reporting System (CRS) has been designated as the national reporting tool for GPRA clinical measures by the IHS Director

Measures Reported by CRS

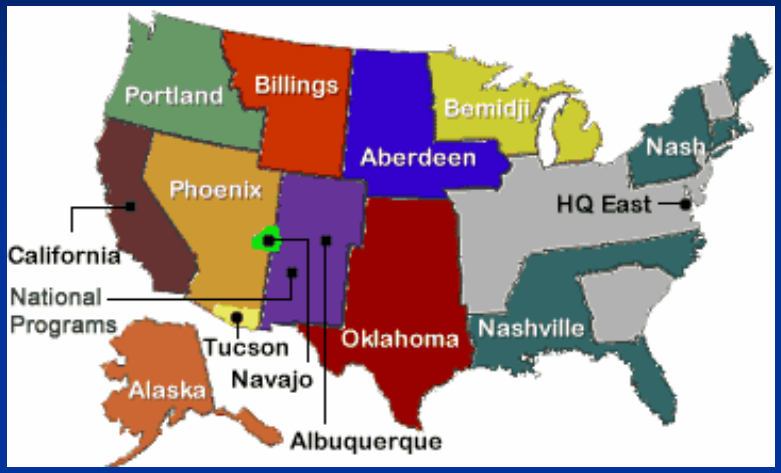
- 21 GPRA *treatment* and *prevention* measures based on RPMS data
- 23 other key healthcare performance measure topics. Examples:
  - Diabetes Comprehensive Care
  - Controlling High Blood Pressure
  - Comprehensive CVD-Related Assessment
- 18 HEDIS measures
- 23 Elder Care measures (patients 55+)
- 10 CMS (hospital) measures

CRS GPRA Reporting

- 2006 GPRA Year is Jul 1, 2005 – Jun 30, 2006.
- National GPRA report now required to be run every quarter
  - 1st Quarter: Contains ~ Jul 1 – Sep 30 data.
  - 2nd Quarter: Contains ~ Jul 1 – Dec 31 data.
  - 3rd Quarter: Contains ~ Jul 1 – Mar 31 data.

  All of the above are compared to the Previous Year and Baseline Year, which contain a full years' worth of data
  - 4th Quarter: Contains Jul 1 – Jun 30 data.

CRS National GPRA Reporting FY 2005



User Population Represented: over 1.3 million patients (96%)

Area	2005	2004	Area	2005	2004	Area	2005	2004
ABR	100%	99%	BIL	81%	81%	OKC	96%	59%
ALK	91%	96%	CAO	96%	99%	PHX	100%	99%
ABQ	98%	100%	NSH	98%	95%	POR	83%	74%
BEM	90%	73%	NAV	99%	100%	TUC	74%	76%

GPRA FY05 Results

- 35 of 36 measures reported
  - 31 met
    - **Includes Influenza measure, on hold in 2004 due to vaccine shortage**
  - 4 not met
- 1 pending results (Unintentional injuries mortality rate)
- 21 clinical measures reported by CRS

GPRA FY05 Results

- 4 Not Met
  - Retinopathy Screening
    - Target: 55%
    - Result: 50%
  - BMI
    - Target: +5% >2004
    - Result: +4%>2004
  - Urban IS Improvement
    - Target: Increase compatible automated information systems: Result: Additional funding needed for remaining programs to capture GPRA data
  - Public Health Infrastructure
    - Target: Assess administrative and public health infrastructure of 3 additional Areas; Result: Inadequate staff and funding prevented assessments

Summary of GPRA FY05 Measures Reported by CRS

Exceeded (13)	Met (6)	Did Not Meet (2)
Poor Glycemic Control	LDL Assessed	Diabetic Retinopathy
Ideal Glycemic Control	General Dental Access	BMI Assessed
BP Control	Pneumovax	
Nephropathy Assessed	Cholesterol Screening	
Dental Diabetic Access	Prenatal HIV Screen	
Influenza	Topical Fluoride	
PAP Screen		
Mammogram		
FAS Screening		
DV/IPV Screening		
Tobacco Use Assessed		
Dental Sealants		
PHN Visits		

Review of Annual Performance Report Executive Summary and 12-Area Summary Report

CRS 2006

Understanding and Using CRS for Performance Measurement Reporting

Background Info

What is CRS?

Performance Measures 101

Clinical Reporting System (CRS)

- Based on software developed by Aberdeen Area in 2000
- Provides automated local and Area tracking of clinical performance on demand
- Intended to eliminate the need for manual chart audits for evaluating and reporting clinical measures

CRS

- Identical logic ensures *comparable* performance data across all facilities
- Updated annually to reflect changes in the logic descriptions and to add new measures
- Local facilities can choose to transmit data for National GPRA, HEDIS & Elder Care performance reporting to their Area
- Area Offices can produce aggregated Area performance reports

CRS Disclaimer

- Software is not a solution
- Software is only a *tool* to assist you (and your facility) in identifying and aggregating *comparable* clinical information
- Software can *help* you identify problems
  - with data
  - with clinical documentation process
  - with clinical care

What is a Performance Measure Topic?

- **Performance Measure Topic**: An overarching clinical topic (e.g., pneumococcal immunization rates)
- Each topic has *one or more*:
  - Denominator: definition of the total population that is being reviewed
  - Numerator: the number of patients from the denominator who meet the criteria identified

Performance Measure Topic Example

Topic:
Pneumovax
Immunization Rates

Denominators:
- GPRA: Active Clinical 65+
- User Pop 65+
- Active Diabetics

Numerators:
- GPRA: Pneumovax ever or refusal during Rpt Period
- Refusal during Rpt Period
- Pneumovax past 5 years

What is a Performance Measure?

- Performance Measure: One denominator and one numerator
- GPRA Measure: The performance measure defined by the agency as a specific performance measure to be reported to Congress

Example: CRS GPRA Measure

- **CRS Denominator:** Active Clinical patients 65 or older.
- **CRS Numerator:** Patients with Pneumococcal vaccine documented at any time before the end of the Report Period, including refusals in past year.

User Population Denominator

- For GPRA, defined as:
  - Must be Indian/Alaska Native, based on Beneficiary classification 01, and
  - Must reside in a community specified in the site's GPRA community taxonomy, and
  - Must be alive on last day of Report Period, and
  - Must have 1 visit to any clinic in the past 3 years

Key Denominator: Active Clinical Population

- Developed specifically for clinical measures to identify more representative "active" population than User Pop
- For GPRA, defined as:
  - Must be Indian/Alaska Native, based on Beneficiary classification 01, and
  - Must reside in a community specified in the site's GPRA community taxonomy, and
  - Must be alive on last day of Report Period, and
  - Must have 2 visits to defined medical clinics in the past 3 years

Active Clinical Population

One of the patient's visits must have been to one of the medical clinics below.

01	General	24	Well Child
06	Diabetic	28	Family Practice
10	GYN	57	EPSDT
12	Immunization	70	Women's Health
13	Internal Medicine	80	Urgent Care
20	Pediatrics	89	Evening

How Does CRS Work?

- "Scavenger" hunt – looks in multiple RPMS packages for any related code
- Logic is based whenever possible on standard national codes
  - e.g., ICD-9, CPT, LOINC and national IHS standard codesets (Health Factors, patient education codes) in predefined taxonomies
- For non-standard terminology, uses site-populated taxonomies populated by each facility with its own codes.
  - e.g., lab tests and medications

Logic Example: Pneumovax

- Active Clinical patients ages 65 and older with Pneumovax documented ever.
  - **Immunization (CVX) codes:** 33 Pneumococcal Polysaccharide Vaccine; 100 Pneumococcal Conjugate Vaccine; 109 Pneumo NOS, *OR*
  - **POV:** V06.6; V03.89, V03.82, *OR*
  - **CPT:** 90669, 90732, *OR*
  - **V Procedure:** 99.55, *OR*
  - **Refusals in past year:** Immunization codes 33, 100, 109

CRS Security Keys

- In order for a user to have access to the CRS application, s/he must be assigned the BGPZMENU security key in RPMS. Other security keys that a user may need are listed below.
  - **BGPZ PATIENT LISTS:** Enables a user to run lists of patients that contain patient identifiers and medical information.
  - **BGPZ SITE PARAMETERS:** Enables a user to edit the site parameters.
  - **BGPZ TAXONOMY EDIT:** Enables a user to edit the site-populated lab and medication taxonomies.
  - **BGPZAREA:** Provides a user with access to the Area Office menu, where Area Aggregate reports may be run.

CRS 2006
Version 6.0

Current Status

Key Changes from Version 5.1

CRS 2006 v6.0: Current Status

- Schedule
  - Began Logic Definition: May 13, 2005
  - Began Programming: June 20, 2005
  - Began Beta Testing: October 21, 2005
  - Released Nationally: November 23, 2005

CRS 2006 v6.0: Key Changes

- Existing measures changed to GPRA measures:
  - Colorectal Cancer Screening
  - Depression Screening
  - Childhood Weight Control
  - Tobacco Cessation

GPRA goals for above measures are to establish baseline rates.

CRS 2006 v6.0: Key Changes

- Existing measures changed to non-GPRA measures:
  - Diabetes: Access to Dental Services
  - Public Health Nursing*
  - Tobacco Use and Assessment
  - Obesity Assessment

*Remains GPRA measure but no longer reported from CRS.

CRS 2006 v6.0: Key Changes

- Key changes to GPRA measures
  - Depression Screening
    - Renamed from Depression/Anxiety Screening
    - Changed age range from 40+ to 18+
    - Addition of new Depression Screening exam code (exam 36)
    - Anxiety component removed
    - All patient education codes removed
    - Addition of refusals to GPRA numerator
    - GPRA Measure: Active Clinical 18+ screened for depression, diagnosis of mood disorder, or documented refusal of screening.

CRS 2006 v6.0: Key Changes

- Key changes to GPRA measures (cont'd)
  - Alcohol Screening (FAS Prevention)
    - Addition of new Alcohol Screening exam code (exam 35)
    - Added refusals in past year
    - GPRA Measure: Female Active Clinical 15-44 screened for alcohol use during Report Period, including documented refusal.

CRS 2006 v6.0: Key Changes

- Key changes to GPRA measures (cont'd)
  - Tobacco Cessation
    - Moved health factors of Cessation-Smoker, Cessation-Smokeless to Tobacco Users denominators (used to be counted as having quit smoking)
    - Added refusals for patient education
    - GPRA Measure: Active Clinical tobacco users who have received tobacco cessation counseling during the Report Period, including documented refusal.

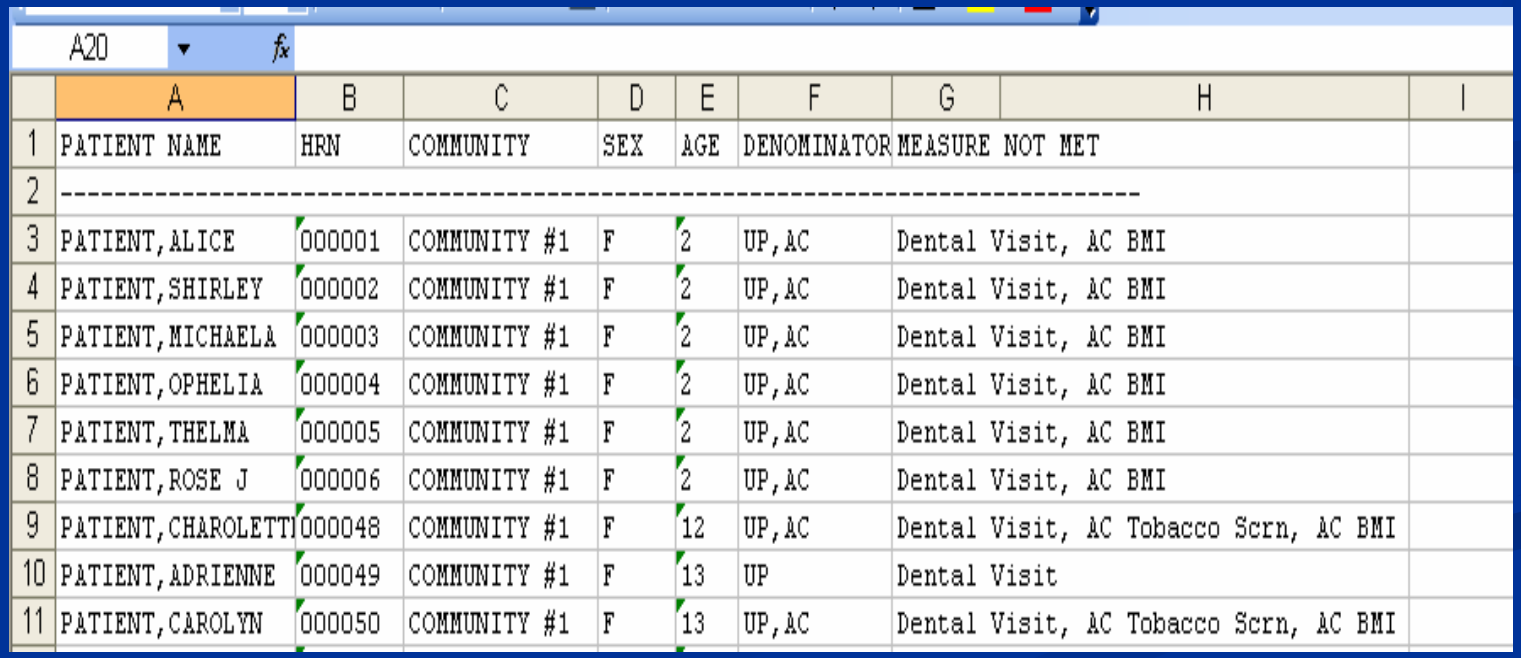
CRS 2006 v6.0: Key Changes

- 3 new measures:
  - Antidepressant Medication Management*
  - Prediabetes/Metabolic Syndrome
  - Osteoporosis Screening in Women

*Also included in HEDIS report.

CRS 2006 v6.0: Key Changes

- New Features
  - Comprehensive National GPRA Patient List
    - Shows patients included in the National GPRA report and which measures they did not meet.



A20

	A	B	C	D	E	F	G	H	I
1	PATIENT NAME	HRN	COMMUNITY	SEX	AGE	DENOMINATOR	MEASURE NOT MET		
2	----------								
3	PATIENT,ALICE	000001	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
4	PATIENT,SHIRLEY	000002	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
5	PATIENT,MICHAELA	000003	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
6	PATIENT,OPHELIA	000004	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
7	PATIENT,THELMA	000005	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
8	PATIENT,ROSE J	000006	COMMUNITY #1	F	2	UP,AC	Dental Visit, AC BMI		
9	PATIENT,CHAROLETTI	000048	COMMUNITY #1	F	12	UP,AC	Dental Visit, AC Tobacco Scrn, AC BMI		
10	PATIENT,ADRIENNE	000049	COMMUNITY #1	F	13	UP	Dental Visit		
11	PATIENT,CAROLYN	000050	COMMUNITY #1	F	13	UP,AC	Dental Visit, AC Tobacco Scrn, AC BMI		

CRS 2006 v6.0: Key Changes

- New Features (cont'd)
  - Site parameter for Contract Health Service (CHS)-only sites
    - Changes Active Clinical definition to require 2 CHS visits in the past 3 years vs. 2 visits to defined medical clinics
  - Site-populated lab and medication taxonomy reports
    - Shows the lab tests and medications associated with a specific taxonomy
    - May be used to show lab and pharmacy staff the tests and drugs used for GPRA and CRS reporting

CRS 2006 v6.0: Key Changes

- New Features (cont'd)
  - GPRA Developmental: Childhood Height and Weight Data File
    - Contains height and weight data for children ages 0-18 for July 1, 1999 – June 30, 2006.
    - Created automatically when site exports National GPRA report to the Area Office.
    - Data will be used in a height and weight study by Epidemiology, in support of a GPRA developmental measure.

CRS 2006
Version 6.1

Current Status

Key Planned Changes from v.6.0

CRS 2006 v6.1

- Schedule
  - Began Logic Definition: October 21, 2005
  - Began Programming: December 5, 2005
  - Begin Beta Testing: Late April 2006
  - National Release: Mid June 2006

CRS 2006 v6.1: Key Changes

- Key changes to GPRA measures
  - Changes to GPRA Targets

Measure	New Target	FY05 Rate	Previous Target
DM Ideal Glycemic Control	32.0%	30.0%	Maintain
DM LDL Ass'd	56.0%	53.0%	Increase
DM Nephropathy	50.0%	47.0%	Maintain
FAS Prevention	12.0%	11.0%	Increase
IPV/DV Screen	14.0%	13.0%	Increase
CVD Cholesterol Screen	44.0%	43.0%	Increase
Prenatal HIV Testing	55.0%	54.0%	Increase

CRS 2006 v6.1: Key Changes

- Key changes to GPRA measures
  - Diabetes: Nephropathy Screening
    - Included patients with any diagnosis ever of ESRD in numerator.
    - GPRA Measure: Active Diabetic patients with positive urine protein test or, if urine protein test is negative, any microalbuminuria test, during the Report period OR with evidence of diagnosis and/or treatment of ESRD at any time before the end of the Report period.

CRS 2006 v6.1: Key Changes

- Key changes to GPRA measures
  - Childhood Immunizations
    - Changed denominator from Active Clinical to Active IMM Pkg patients.
    - GPRA Measure: Patients active in the Immunization Package who are 19-35 months at end of Report Period who have received the 4:3:1:3:3 combination (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B), including refusals, contraindications, and evidence of disease.
    - Impact: A site must be using the Immunization Package to meet this measure.

CRS 2006 v6.1: Key Changes

- Key changes to GPRA measures
  - Colorectal Cancer Screening
    - Added exclusions for patients with total colectomy.
    - Revised timeframe for FOB test from past 2 years to past year.
    - GPRA Measure: All Active Clinical patients ages 51-80 without a documented history of colorectal cancer or total colectomy who have had ANY CRC screening, defined as any of the following:
      - Fecal Occult Blood test during the Report period
      - Flexible sigmoidoscopy or double contrast barium enema in the past 5 years
      - Colonoscopy in the past 10 years
      - Documented refusal in the past year.

CRS 6.1 Key Changes

- National GPRA Report
  - Added the following non-GPRA measures
    - CVD and Blood Pressure Control
    - Beta-Blocker Treatment After AMI
    - Persistence of Beta-Blocker Treatment After AMI
    - LDL After Cardiovascular Event
    - Prediabetes/Metabolic Syndrome

CRS 6.1 Key Changes

- Fixes to Existing Non-GPRA Measures
  - **Comprehensive CVD:** Fixed problem for tobacco screening numerator that did not count patients with tobacco screening documented with a health factor.
  - **Osteoporosis Management:** Fixed problem for treatment or testing numerator for fractures diagnosed at outpatient visit where logic was requiring the treatment or testing within 60 days of a fracture instead of 180 days (6 months) after the fracture.

CRS 6.1 Key Changes

- New Measures (non-GPRA)
  - Adolescent Immunizations*
  - Treatment for Children with Upper Respiratory Infection*
  - Appropriate Testing for Children with Pharyngitis*
  - Rheumatoid Arthritis Medication Monitoring
  - Osteoarthritis Medication Monitoring
  - Asthma Patients and Inhaled Steroid Use

*Also included in HEDIS report.

CRS 6.1 Key Changes (cont'd)

- New Features
  - Option for creating a search template from a National GPRA patient list.
  - MFI Site Parameter - Alaska Area Only
    - Denominator logic will look for visits ONLY at facilities defined by the user vs. looking at visits from all facilities on the database.

CRS 6.1 Key Changes (cont'd)

- CMS Report
  - Make revisions to existing 10 hospital measures, per CMS
  - 7 new hospital measures
    - AMI
      - Thrombolytic agent received within 30 minutes of arrival
      - PCI received within 120 minutes of arrival
      - Adult smoking cessation advice/counseling
    - Heart Failure
      - Discharge instructions
      - Adult smoking cessation advice/counseling
    - Pneumonia
      - Blood culture performed before first antibiotic received in hospital
      - Adult smoking cessation advice/counseling

For more info, visit our website:

www.ihs.gov/CIO/crs

Standard Codesets and Taxonomies

What Are They?

How to Set Up and Manage

Common Problems

Standard Codes

- Hard-coded in CRS program logic; users cannot change the codes
- Types of Standard Codes
  - CPT: to report diagnostic and therapeutic procedures for billing
  - ICD:
    - Diagnoses (POV, Problem List)
    - Procedure codes
  - LOINC: for laboratory tests, etc.
  - IHS National Patient Education Codes
  - IHS Health Factors

Patient Education Codes

- Patient Ed codes "count" toward the following measures
  - Alcohol Screening*
  - IPV/DV Screening*
  - Tobacco Use Assessment
  - Tobacco Cessation*
  - Nutrition and Exercise Education for At Risk Patients
  - Medications Education
  - Prenatal HIV Counseling

*GPRA measure

Patient Education

- Documenting patient education
  - disease state, condition or system addressed
  - specific education topic
  - level of understanding
  - who provided (initials) and time spent
- DM – M – G – xyz - 10 min

www.ihs.gov/NonMedicalPrograms/HealthEd/
click on "National Patient Ed Initiative"

Example of Standard Codes in CRS Logic

- To define Pap Smear (past 3 years):
  - V Lab: Pap Smear (standard test name), *OR*
  - Site-populated taxonomy BGP GPRA PAP SMEAR, *OR*
  - LOINC taxonomy, *OR*
  - V POV: V76.2, V72.31, V72.32, V72.3 (old code), V76.47, or V76.49 Screen Mal Neop-Cervix, *OR*
  - V Procedure: 91.46, *OR*
  - V CPT: 88141-88167, 88174-88175, Q0091, *OR*
  - Women's Health procedure Pap Smear, *OR*
  - Refusals in past year

Taxonomies

- Groupings of functionally related data elements
- Used by RPMS applications, including CRS, to find data items in PCC

Taxonomies

- 2 Types of Taxonomies in CRS
  - Hard-coded
    - Users cannot update.
    - LOINCs are included in these.
  - Site-populated
    - Users update with System Setup menu option.
    - All non-LOINC lab tests are included in these.

Site-Populated Taxonomy Examples

TEST	VARIATIONS
DM AUDIT HGB A1C TAX All Hemoglobin A1C lab tests – used in Diabetes: Glycemic Control	HgbA1C A1C HbA1c Hemoglobin A1C Glycosylated hemoglobin Glycohemoglobin A1c
DM AUDIT MICROALBUMINURIA TAX All Microalbuminuria Lab Tests – used in Diabetes: Nephropathy Assessment NOTE: Tests for Microalbuminuria/ Creatinine should be included in DM AUDIT A/C RATIO taxonomy.	Microalbuminia Micral Microalbuminia Microalbuminuria Micro-Albumin

Taxonomy Tips

- You must work with your Lab staff to identify all test names
  - would you know that Lipid panels at your site are named “Coronary Risk Panel”?
- Include ALL test names used by your facility since 1995, even if codes are currently inactive

Taxonomy Tips

- Don't include names of lab panels in taxonomies for specific tests that look at results (e.g., "Lipid Panel" should NOT be included in LDL taxonomy)
- Think about converting to LOINC

Reports and Patient Lists

National GPRA

GPRA Performance

Selected Measures

HEDIS Performance

National GPRA Report

- Includes GPRA measures and other key clinical measures
- Hard-coded report parameters
- Includes Clinical Performance Summary that compares local performance to last year's national performance
- May be exported to Area for aggregation
- Can run *separate option* for Patient Lists
- Required to be run quarterly

GPRA Performance Report

- Exact same content and logic as the National GPRA report
- User selects the Report Period and Baseline Year
- User selects patient population (e.g. AI/AN)
- May be exported to Area for aggregation
- Can run *separate option* for Patient Lists

Selected Measures Reports

- All performance measure topics available
- Users may choose the topic(s) for the report or choose from predefined groups (e.g. Diabetes, Women's Health, etc)
- All denominators and all numerators included for the selected topics
- Users select the report parameters
- User can produce Patient Lists with report

Report Format (National GPRA and Selected Measures)

HEDIS Report

- 18 HEDIS measures
- May be run for sites seeking NCQA certification
- May be exported to Area for aggregation
- User select the report parameters
- Patient Lists available

Area Aggregate Reports

- For National GPRA/GPRA Performance, HEDIS, and Elder Care reports
- Aggregates selected data files received from sites and produces Area summary report
- Individual uploaded data files must have matching time periods (date range, report year, AND baseline year) *and* populations (e.g. AI/AN only)

Patient Lists

- Options available
  - Random sample (10%)
  - By designated provider
  - All patients
- National GPRA patient lists: User chooses to include:
  - Patients meeting the measure (i.e. included in numerator), or
  - Patients not meeting the measure, or
  - Both

Patient Lists

- Selected Measures, HEDIS, and Elder Care patient lists: Depending on measure, may include:
  - Patients meeting the measure (i.e. included in numerator)
  - Patients not meeting the measure
  - Both

Patient Lists Can Be Used For...

- Verifying RPMS data against patient's chart info
- Identifying patients who need certain screenings/procedures
  - e.g., A1c, flu shot
- Identifying "at risk" patients
  - e.g., high LDL, high BP, obese
- Delimited files are most useful output for patient lists

Patient List Format (See Example in Training Notebook)

Using CRS Reports Locally

- Public health studies for one or multiple specific clinical topics
  - for entire service area
  - for one specific community
- Different provider specialties can track their own areas of interest
  - women's health, diabetes, etc.
- Individual provider can focus on own patients
  - Patient Lists by Provider
  - Run report on patient "panel"

Demo

Discussion of Who Should Have Access

Demo of System Setup

Demo

Taxonomy Setup

Demo

National GPRA and Selected Measures Reports

National GPRA Patient Lists

Delimited Reports (Excel)

Demo

CRS GUI

Report Results

Common Reasons for Low Rates

Tips for Improvement

Improving GPRA Performance Requires a Team Effort!

Report Results

- Low or "incorrect" results on your CRS reports does not necessarily mean that you are not performing the appropriate procedures, screenings, etc
- It does mean that the data cannot be located in RPMS
- First, check what's in the chart against what's in RPMS
  - Use Patient Lists

Common Reasons for Low Rates

- BMI
  - Children not having both height and weight entered on same day
  - Adults not having a height taken in past 5 years
  - Measurements being recorded as cm/kg vs. in/lbs and provider not noting they are cm/kg AND/OR data entry not entering correctly in PCC
    - Mnemonics of CHT and KWT, or
    - Adding "c" after height value and "k" after weight value (e.g. 100c, 50k)

Common Reasons for Low Rates

- Tobacco Screening
  - National Health Factors not used
  - Health factor not entered into RPMS
- LDL and other lab tests
  - Taxonomies not current – talk to Lab staff
  - Lab tests sent out but not recorded in PCC as historical lab
    - Reference Lab interface will fix this problem

Tips for Improvement

- Ensure Data Entry is up-to-date
  - Final GPRA reports are due to CAO by August 4, 2006. The end of the GPRA report period is June 30, 2006.
  - Reports at local facilities will be run in July.
  - If data entry is >4 weeks behind, all of the data that is entered after July will not be counted in this year's GPRA report!!!

Tips for Improvement

- Review your GPRA community taxonomy
  - Ensure all communities in your service area are included in the taxonomy
    - Your site or Area Planning Officer or Statistician should be able to assist in defining appropriate communities
  - Find out if any name changes have been made to communities in your taxonomy
    - If yes, need to change taxonomy to delete old community and add new community

Tips for Improvement

- Document and enter refusals
  - Refusals count toward meeting many measures
    - Pap, mammogram, immunization, diabetic eye exam, CRC screen, etc.
  - Providers: document on PCC
    - Write in POV section "Refused ___" (depending on test, IZ, or other procedure)

    OR
    - Write "Refused" in appropriate Order Box at right
  - Data Entry: use REF mnemonic

Tips for Improvement

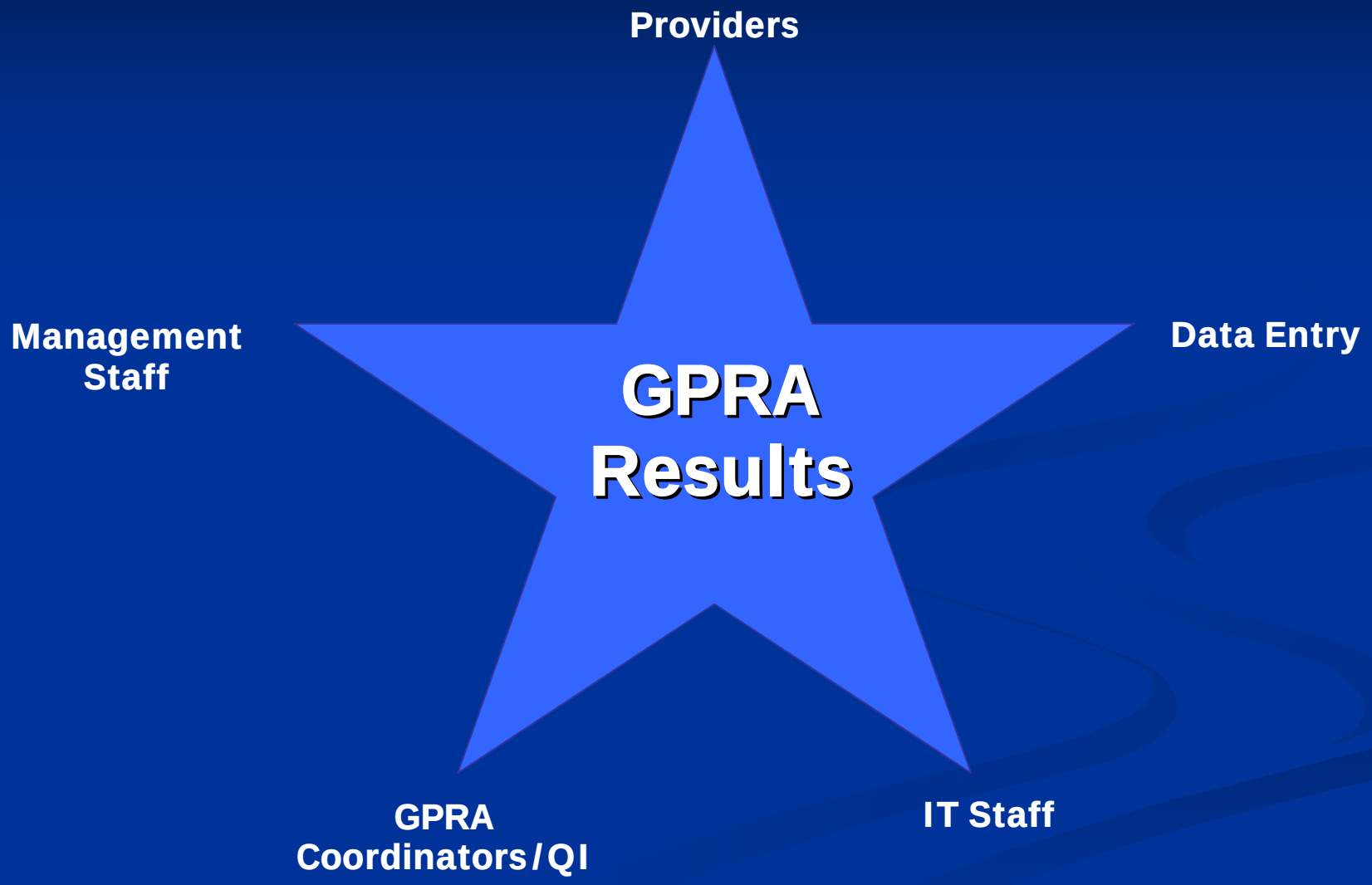
- Document historical lab tests and procedures
  - Providers: Ask about and record historical information on PCC
    - Ask patients about common off-site procedures (e.g., IZ type, date received, location)
    - Document telephone visits
    - Verbal or written lab or other referral reports
  - Data Entry: Use Historical Mnemonics

    HIM (Immunization) HPAP (Pap Smear)
    HRAD (Radiology) 76090-76092 for mammogram
    HBE (Barium Enema) HCOL (Colonoscopy)
    HFOB (FOBT, guaiac) HSIG (Sigmoidoscopy)

Tips for Improvement

- Include all relevant lab tests for taxonomies
  - Update taxonomies at least annually because the Lab updates lab profile and codes periodically throughout the year
  - Include changed, inactive, deleted and current tests in your taxonomy because CRS looks at tests as far back as 1995
  - Coordinate with lab tech to assure ALL codes identified. They may know names of tests you wouldn't know.
- Document reference lab results
  - If labs are sent out, ensure that test completion and result are entered in PCC when returned

Improving GPRA Performance Requires a Team Effort!



Team Effort

- **Providers**
  - Ask patients the questions that need to be asked (e.g. do you smoke, drink) and get heights, weights, and BP. Document the information on the encounter form in the appropriate place.
  - Document patient refusals, patient education, and health factors.
  - Ask patients about off-site procedures and document on PCC form.
  - Ensure Data Entry staff know what to look for on PCC forms and how to enter into PCC.
  - If you are responsible for running the CRS reports, ensure you have received training on how to run the reports and which reports are best to run.
  - Review the National GPRA report for the measures that are applicable to you. For example, if you are a dentist, review the GPRA dental measures.

Team Effort

- **Data Entry**
  - If at all possible, ensure you are not behind in entering your data into PCC and other packages CRS looks at.
  - Ensure you understand how everything on the encounter form is to be entered into PCC. If you don't, ask the provider.
  - If a provider writes something on the encounter form that is not in the correct place, let him/her know where it should be annotated.
  - Ensure you know the mnemonics for entering refusals and historical data. Obtain a copy of the CRS Clinical Cheat Sheet that provides information on entering data for several GPRA measures.

Team Effort

- **IT Staff**
  - Ensure the current version of CRS and all required patches are installed in a timely manner at your facility.
  - Assist personnel with locating their CRS report files.
  - If you are responsible for running the CRS reports, ensure you have received training on how to run the reports and which reports are best to run.
  - Ensure the CHS to PCC link is on at the facility. If it isn't, CHS data is not being passed to PCC and could negatively impact GPRA rates for procedures paid with CHS funds, like mammograms or dental care.

Team Effort

- **GPRA Coordinators/QI**
  - If you are responsible for running the CRS reports, ensure you have received training on how to run the reports and which reports are best to run.
  - Review your site parameters to ensure they are setup correctly.
  - At least annually, review the site-populated taxonomies for lab tests and medications.
    - If a lab test your facility commonly uses is not included in the taxonomy for a GPRA measure, your results could be very low!
    - Ensure lab tests that were used from 1995 until now are included since the reports compare to performance in 2000 and some measures look back 5 years for a test, such as colorectal cancer screening.
    - Deactivated tests may be prefixed with a "z" or "Z" or some other convention. Ask your lab staff how they deactivate old tests and ensure they are in the taxonomy.

Team Effort

- **GPRA Coordinators/QI (cont'd)**
  - Review your GPRA community taxonomy to see if all communities that should be included are included.
  - Review the National GPRA report. Also provide the report to providers who are responsible for the measures to get their input. Do not wait until the last minute to do this!
    - Do the rates look reasonable? If not, obtain a copy of the patient list(s) for the measure(s) and compare with the charts to see where problems may exist:
      - Is the data in the chart but not in PCC? Does the data entry staff need to be advised on how to enter it in PCC? Was it documented in the correct place on the encounter form?
      - Was the data in PCC but documented with a code CRS is not looking for? Should CRS be looking for it?
      - Did the patient not receive the screening/test/IZ? If yes, schedule an appointment for the patient.

Team Effort

- **Management Staff (e.g. Area & Service Unit Directors)**
  - Attend the GPRA and CRS Overview class. This presentation will help you understand how GPRA reporting impacts your performance contract, understand the GPRA measures, and the CRS application that is used for reporting on GPRA.
  - Recognize employees who take the initiative to improve GPRA performance.
  - Solicit information from facilities who are GPRA achievers to see if there are processes they have implemented that may be implemented at facilities that need improvement with their GPRA rates.
  - Communicate with your staff the importance of GPRA and how it can make a difference in our patients' health status .

Identify Problem Measures NOW!

- Run National GPRA report every quarter
- Identify measures that have low rates or seem incorrect
- Run National GPRA Patient Lists for "problem" measures
- Compare with RPMS data to identify potential data or clinical process issues and resolve
- Re-run report

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